Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-1852-01
REHAB 2112 200 WYNNEWOOD VILLAGE DALLAS, TX. 75224	
Respondent Name and Box #:	
AMERICAN ZURICH INSURANCE CO. REP. BOX # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Work Hardening programs that are exempt from the DWC and do not exceed the ODG recommendations do not require preauthorization…."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $6176.00
3. CMS 1500s
4. EOBs
5. CARF accreditation letter
6. ODG treatment guideline
7. Medical records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…Carrier asserts that it has paid according to applicable fee guidelines…."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
6-24-09 6-25-09 6-26-09 6-29-09 6-30-09 7-1-09 7-2-09 7-6-09 7-7-09 7-8-09 7-15-09	97545-WH-CA-GP 97546-WH-CA-GP (x5 units/hours)	19	1, 2, & 3	$1408.00 $3520.00

7-3-09	97545-WH-CA-GP 97546-WH-CA-GP (x3.5 units/hours)	19	1, 2, & 3	$128.00 $224.00
7-9-09 7-13-09	97545-WH-CA-GP 97546-WH-CA-GP (x5 units/hours)	No EOBs	1 & 4	$0.00 $0.00
Total Due:				$5280.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services effective* for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "19" (precertification/authorization exceeded).
2. In accordance with Rule 134.600 (p) (4), only non-exempt work hardening programs require pre-authorization. The Requestor is CARF accredited and is exempt from pre-authorization, as evidenced by the Division's website for 'DWC program exempt status'. Per Rule 134.204 (h) (1) (A), if the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific program. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR (maximum allowable reimbursement).
3. In accordance with Rule 134.600 (p) (12), treatments and services that exceed, or are not addressed by the Commissioner's adopted treatment guidelines or protocols (ODG-*Official Disability Guidelines*) and are not contained in a treatment plan preauthorized by the carrier require pre-authorization. A review of the ODG for the billed diagnosis code of 846.0 identifies that the work hardening program timelines shall not exceed 20 full-day visits over 4 weeks or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). The total number of days submitted on the Disputed Table equal fourteen. The Requestor holds CARF accreditation and its facility holds a Division exempt status. Additionally, the number of treatments provided fall within the ODG recommendations and therefore payment is recommended pursuant to Rule 134.204 (h) (3) (A) (B). The appendage of the "GP" modifier is considered as service descriptive and represents no monetary value.
    - 97545-WH-CA: $64.00 per hour
    - 97545-WH-CA (initial 2 hour code): $64.00 x 2 = $128.00 x 11 DOS = $1408.00
    - 97546-WH-CA: $64.00 x 5 hours = $320.00 x 11 DOS = $3520.00
    - 97545-WH-CA (initial 2 hour code): $64.00 x 2 = $128.00
    - 97546-WH-CA: $64.00 x 3.5 hours = $224.00
4. These two DOS were not listed/identified on the submitted EOBs. Pursuant to Rule 133.307 © (2) (B), the Requestor submitted no convincing evidence of carrier receipt of these DOS and therefore payment can not be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.204, 133.307, 134.600
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $5280.00 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

		12-22-09
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.